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The Clinical Sociologist as Family Therapist: Utilizing the Strategic Communication Approach

Gary M. Voelkl

Kenneth Colburn Jr.

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Gary M. Voelkl and Kenneth Colburn, Jr.

ABSTRACT

This article acquaints the clinical sociologist with the sociodynamic model underlying the family therapy approach associated with the "Palo Alto" group and referred to here as the strategic communication approach to family therapy (SCAFT). It establishes the relevance and compatibility of this form of therapy to sociological theory and practice. The basic features of the field of family therapy are described through a selected treatment of several prominent contributors. The authors illustrate the utility of SCAFT for the clinical sociologist by drawing on case studies from their private practice. In the conclusion they emphasize the continuity between SCAFT and sociological principles.

Introduction

As Hansen and L'Abate have observed, "One of the most unfortunate gaps for the field of family therapy is its separation from the field of family theory as found in sociology" (1982:296). This paper attempts to close the gap between family therapy and sociology by drawing the strategic communication approach to family therapy (SCAFT) to the attention of clinical sociologists.

In the sociodynamic perspective, problems are interpreted as being created by the social organization of human relationships. One may learn about that organization by attending to sequences of interaction as they occur among group members. Moreover, by observing the sequences of communication within a group, a therapist becomes acquainted with the distribution of influence within that group. A consideration of the element of power in a social system and the members' attempts to secure it is useful to one operating from a sociodynamic model. In this paper the sociodynamic perspective is related to family therapy, and implications of both for clinical sociology are explored.

A Historical Overview of Family Therapy

Any attempt to summarize or define the field of family therapy must, at present, be understood as necessarily tentative and incomplete because of the field's disciplinary and theoretical diversity, its relatively recent and intense growth, and its developmental character. Our attempt to provide a selected overview of the field represents an oversimplification and cannot be substituted for more extensive reading (see Beels and Ferber 1969; Sporakowski and Mills 1969; Olson 1970; Hansen and L'Abate 1982; Horne and Ohlsen 1982).

The mid-1950s is recognized by most authors (e.g., Olson 1970; Hansen and L'Abate 1982) as the starting point of the modern family therapy movement. While, strictly speaking, family therapy can be traced back to the child guidance clinics of the 1920s, the profession of psychiatry gained early control over the organization and methods of treatment employed in these clinics, resulting in the application of traditional personality or intrapersonal models of human conduct to troubled families. Traditionally, the psychiatrist saw the child, the psychologist conducted the diagnostic testing, and the social worker saw the mother — more often than not the father was left out of the treatment plan (Olson 1970:504).[2] In this traditional clinical setting, the key feature of modern family therapy is absent — namely, the shifting of the theoretical and therapeutic perspective from the individual to the relationship between self and others comprising the family system. Clearly it is *relationship-oriented* theory and procedures, focusing on the family as a social interaction system, that distinguishes family therapy from the traditional psychotherapeutic emphasis on the individual personality and biography.

Nathan W. Ackerman (1958; 1966; 1970) is perhaps the earliest and most widely known proponent of family therapy. Although trained as a psychoanalyst and child psychiatrist, Ackerman was influenced by social psychology and its emphasis upon understanding the individual in terms of the social situation. He published a paper on the family as a social emotional unit in 1937, began experimenting with family therapy treatment in the late 1940s, and became the director of the first Family Mental Health Clinic in New York City in 1957. In 1962 he joined Don Jackson to found the first journal of family therapy, *Family Process.*

Ackerman occupies a special place in the field of family therapy; although he did not completely abandon the traditional psychotherapeutic viewpoint of his training, he realized the need for new thinking and approaches to the individual which took into account his or her family situation and social involvement with other family members. Here he borrowed the concept of *social role* from the work of Kurt Lewin, which permitted him to identify reciprocal and complementary roles among family members. Two notions

beyond that of social role are important to Ackerman. The first is that of *family identity*, the way each family group defines its purposes and goals, a definition that is reflected and expressed in some way by each family member; the second is the notion of *family stability or equilibrium*. Believing that there is no essential difference between a healthy family and a sick family, Ackerman thought that problems resulted from a family's inability to maintain the necessary flexibility or responsiveness among its various role relationships to permit the optimum adaptation for the family system as a whole. The aim of therapy is to help a family achieve this stability by working with members in such a way as to make greater role adaptation possible. This would increase the family's ability to resolve conflict in positive ways. Ackerman emphasized that the clinician must see and work with all members of the family during the early and middle phases of therapy, to create opportunities for both firsthand observation and direct intervention in the family interaction. It is the addition of this latter focus on the family as the unit of treatment that qualifies Ackerman's work as family therapy.

Like Ackerman, Murray Bowen (1961; 1965; 1976; 1978) was medically trained in the psychoanalytic mode of therapy and found this approach in need of revision in the light of his research at the National Institute of Mental Health with families of schizophrenics. During the mid-1950s, Bowen invited families of schizophrenic patients to live in the hospital wards so they could be observed and intervened with more effectively as a family group. Although Bowen accepted the psychoanalytic account of the origins of the emotional conflict experienced by his patients, he did not find the therapeutic techniques of psychoanalysis to be effective in treating the more severe cases. Bowen's theory and practice emerged from his efforts to modify psychoanalysis to treat schizophrenics in their family context.

Bowen's theory centers on two main concepts: the *degree of anxiety* experienced by a person and the *degree of integration of self*. Bowen views emotional illness as rooted in the system of relationships in the family, involving *interlocking triangles* that reach over more than one generation. He proposes that the dyad he viewed as inherently unstable, for when anxiety arises, a third person is brought in to relieve the strain, creating an interlocking triangle. The reduction of anxiety made possible by this new triad permits the persons involved to return to their previous structure of relationships. With low anxiety it may be possible for all members of the triad to relate to one another as individuals; the ability of a person to relate as a differentiated individual within the family is a primary focus of therapy. Bowen's basic therapeutic assumption is that if individual differentiation occurs, the change thus brought about in the individual will bring about a change in the family system.

Self-differentiation for Bowen is a person's ability to separate intellectual from emotional functioning, with the more differentiated self being able to

engage in cognitive rather than emotive reasoning and behavior. Intellectual control of one's life, experiences, and social situation is seen to make possible greater flexibility in response to critical life situations; hence control is gained over the anxiety which they can produce. Bowen's approach relies heavily on the psychodynamic model stressing intrapersonal factors, even if somewhat modified by a family systems perspective. The therapeutic focus of family therapy for Bowen seems to remain on the level of individual treatment, although theoretically the social relationships between family members are stressed. The interactional or transactional patterns between family members, involving communication, are of less concern for Bowen than for Ackerman.

The strategic communication approach to family therapy evolved during Gregory Bateson's decade of research (1952-62) and focused on the communication patterns of families with schizophrenic members in the Veterans Administration Hospital, Palo Alto, California. Bateson's project staff included Don D. Jackson, John Weakland, and Jay Haley. Out of this project the now-famous *double-bind theory of schizophrenia* was developed (Bateson et al. 1956). The basic idea of this theory is that schizophrenic behavior is not simply an individual phenomenon; it is rooted in communicative patterns of interaction between family members that both generate and sustain one member's apparent schizophrenic conduct. In the typical double-bind situation, two contradictory messages are simultaneously given from parent(s) to child, one direct and the other indirect. As a consequence, an adequate response on the part of the child is impossible, which results in schizophrenic behavior — viewed then as an adaptive response by the child to the double-bind into which it has been placed.

In 1958 Jackson founded the Mental Research Institute (MRI) in Palo Alto. It attracted such persons as Haley, Virginia Satir, and Paul Watzlawick. Haley became the first editor of *Family Process,* which was sponsored both by the MRI and the Family Institute of New York (directed by Ackerman).[3] Under Jackson's leadership, the MRI began to study and train professionals in conjoint family therapy — Jackson's term for treatment in which all family members are seen together by the therapist.

Jay Haley ranks among the most innovative and dynamic, if somewhat controversial, figures in contemporary family therapy. Much of the freshness of Haley's approach to family therapy, rooted primarily in communication theory, is no doubt related to the fact that he was not formally trained as a psychoanalyst, a clinical psychologist, or a psychiatrist. Joining Jackson at the MRI in 1962, after the Bateson project had ended, Haley continued to study communication and learned about role theory (1978); he also became involved in research on *covert coalitions* (1962), the notion that the identified patient reflects a coalition of two persons against the patient. During this time Haley also identified power struggles within the family as a key issue of therapy,

especially since the therapist's intervention in the family poses the prospect of his being enlisted by one or more family members as part of the coalition striving for dominance over other members. Haley emphasizes the dimension of power in all social relationships, suggesting that an essential but indirect feature of all communication involves claims and counterclaims to dominance and deferral within relationships. He defined three types of relationships: symmetrical, complementary, and metacomplementary (Haley 1963). A symmetrical relation is one in which power is roughly equivalent between self and other; more or less the same kind of behavior is engaged in and exchanged by both parties. A complementary relation is one in which self and other exchange different sorts of behavior (for example, teacher-student or therapist-client). Here a power differential exists between the two, revealing a superordinate and a subordinate status. Rules for the relationship are less likely to be determined equally by both parties. In the metacomplementary relationship, the person ostensibly with less power — the subordinate — in fact permits the other to take control, thereby creating a situation in which the subordinate actually has power over the superordinate (cf. Haley 1973).

In the mid-1960s Haley was invited to become research director at the Philadelphia Child Guidance Clinic.[4] He established relationships with two prominent therapists who subsequently influenced his work: Salvador Minuchin, who was developing a theory of structural family therapy, and Milton Erickson, from whom Haley learned about paradoxical interventions. It is during this time that Haley's reputation and influence as a family therapist became firmly established. (Since we will explicate the SCAFT primarily through reference to Haley's work, we will defer to the following section further discussion of it. Currently, Haley is clinical professor of psychiatry at George Washington University and director of the Family Therapy Institute in Washington, D.C.).

Salvador Minuchin is an important figure in the field of modern family therapy; although he is not identified as a member of the strategic communication approach to family therapy, his influence on SCAFT and his social structural emphasis are clear. Minuchin began his career as a psychiatrist and psychoanalyst, but over time developed techniques and theories that radically departed from the intrapersonal theory and individual treatment model of those disciplines. Focusing on careful and systematic observations of family processes and structures, including communication, Minuchin has based his work solidly on the premise that the individual cannot be understood apart from his or her social context. He holds that changing the structure of the indivudal's social situation (for example, the family structure) will result in change for the individual.

More than any other studies by contemporary family therapists, Minuchin's work reflects the sociological perspective of structural-

functionalism in both theoretical outlook and language. Minuchin defines family structure as a set of functional imperatives that organizes the modes in which members interact. Preferential patterns of interaction constitute transactional rules concerning how, when, about what, and to whom family members should typically relate. These *transactional patterns* regulate family behavior and are both rooted and reflected in the subsystems of a family. At least three such subsystems can be identified: spouse, parent, and sibling. Various social skills are associated with each, and Minuchin suggests that family functioning can be determined for a particular family by the degree to which the boundaries between subsystems remain fairly clear and operational during member transactions. Boundaries between subsystems enable the family to maintain the necessary differentiation of its structure for it to function well.

The concept of boundary is probably the most basic and best-developed element of Minuchin's therapeutic model. Minuchin suggests that all families operate between two extremes of *ambiguous boundaries* and *inflexible boundaries*. The difference between a normal and pathological family is one of degree and not of kind; pathology is indicated only when a family operates solely at one end of the continuum. The condition of blurred boundaries between the subsystems of a family is referred to as *enmeshment* and the situation of rigid boundaries is termed *disengagement*. Communication is increased and intensified to a dysfunctional level in the first case and is decreased to a dysfunctional level in the second case. Both transactional patterns are seen by Minuchin as dysfunctional because the family is unable to respond well to demands for change. The restructuring of family transactional patterns and the restoration of clear but flexible boundaries between subsystems is a major focus of the therapeutic intervention for Minuchin.

Basic Assumptions of SCAFT

The strategic communication approach to family therapy is best thought of as the identification of a core set of assumptions — Kuhn's concept of a paradigm (1962) is relevant — around which somewhat different conceptual emphases and clinical techniques have evolved. There is much diversity within what we have termed SCAFT, and we do not mean to imply that all persons associated with this perspective would find themselves in agreement over many substantive and conceptual matters. Our position is that a distinctive perspective can be identified within the field of family therapy.

The first and perhaps central assumption behind SCAFT is the communication theory derived from the Bateson project. This theory involves a twofold emphasis upon (1) the nature and structure of communication and (2) the social context of communication. Communication is viewed as occurring on different levels simultaneously, giving rise to the possibility of multiple

and contradictory messages and meanings. It is also understood to be both embedded and reflected in the social relationship between two or more persons.

Thus, Haley (1976:83) has made the distinction between *digital* and *analogic modes of communication.* Digital communication is directed solely and specifically to a particular referent. In contrast, analogic communication is metaphorical; its referent is a matter other than what is specifically referred to in the discussion. Since communication reflects the social relationship in which it occurs, at least some aspect of all communication can be recognized as an analogy or metaphor about that relationship. For example, Haley (1976:32) suggests that a therapist must remain cognizant of the possibility that family members will offer indirect messages about someone other than the person directly referred to: a mother complaining that her son is too aggressive and hits her may be making an indirect statement about her husband — but it remains outside her level of awareness. A therapist must be aware of, anticipate, and be prepared to use this metaphorical aspect of communication in his or her approach to therapeutic intervention.

A second assumption underlying SCAFT is that all social relationships involve the dimension of power; it is by no means unusual for communication at least indirectly to be concerned with power and control. Power also suggests issues of hierarchy and stratification within relationships. A clinical application of this viewpoint is that at least some family or marital problems can be interpreted in terms of the inability of persons to resolve the issue of power and control.

A third assumption is that the therapist, as an expert called upon by a family, cannot fail to influence — for better or for worse — a family's interaction system. Given recognition of this fact, the issue is not whether but rather how the clinician will make use of and accept responsibility for this influence. SCAFT emphasizes an active, interventionist approach on the part of the therapist, consisting of the explicit formulation of a strategy designed to solve a client's presenting problem. The object of change is the social structure of relationships within the family, especially the balancing of power and the restoration of the hierarchy, for example, of parents over children. Change is brought about through a series of stages involving the use of directives from the therapist: *directives* are prescriptions for behavior suggested to a family that are designed to alter relationships in ways the therapist sees as more desirable for family functioning. Although clients obviously must assume responsibility for carrying out such directives, and an important task of the therapist is to motivate families to do so, the prescription of directives is the responsibility of the therapist and not the client.

Unlike traditional forms of psychotherapy, which emphasize insight and growth on the part of the client, SCAFT, through its use of directives, does not

recommend that the therapist share hypotheses concerning the cause of a family problem. Directives are designed to introduce new and alternative patterns of behavior within relationships and are intended to solve problems rather than reveal either the client's feelings about a problem or foster the client's emotional or cognitive growth. Since SCAFT views the therapist as part of a system, the aim of the therapist is to use his or her temporary leverage to induce change in the family structure and communication patterns. In this way, a change in individual feelings and attitudes should ensue. It is essential that the therapist be aware of coalitions within the family and enter these only with a definite therapeutic goal.

A final assumption of SCAFT, relating also to communication theory, is the use of paradox by the therapist. SCAFT tends to dispense with traditional psychiatric lablels such as "manic depression" or "delinquency" because it is felt that such diagnostic categories are not solvable problems. Likewise, SCAFT is not concerned with discovering the etiology of a problem or a client's past; the emphasis is on determining and changing a recurring sequence of activity between two or more persons (cf. Madanes 1981:chapter 2). Change is brought about by preventing the repetition of sequences through the introduction of alternative ways for members to relate to one another. The use of *paradoxical directives* by the therapist is of special interest in this connection. A paradox — that is, a message that is contradictory across at least two levels of meaning — requires that the client confront his or her usual way of behaving. For example, the statement "I want you to be spontaneous and independent of anyone's wishes" involves a paradox that cannot be resolved in a perfectly satisfactory way. Whether the person attempts to resist or comply with the speaker's suggestion, some degree of contradiction will emerge.

Haley (1976:68) suggests that paradox can be used by the therapist in dealing with families that seem to be resistant to any change in family interaction patterns. In such cases, a direct approach by the therapist tends to be futile. Examples of paradoxical directives are offered by Haley (1976:72-76).

Application and Case Studies

In this section we illustrate SCAFT by offering two case studies drawn from the authors' joint private practice in clinical sociology. We have limited our examples to the consideration of a problem that is far from uncommon in our practice — namely, the therapeutic issue of restoring the balance of power in a marital relationship. We do not discuss basic therapeutic skills in this discussion since we are concerned primarily with showing how the clinical sociologist utilizing SCAFT conceptualizes problems and intervenes in concrete situations. All names are, of course, fictitious.

Reflecting the traditional and preponderant use of the individualistic, psychodynamic approach to human problem solving and its adoption by lay culture, clients will generally formulate their concerns in terms of the characteristics of one family member, who is thought to be "the problem." It is assumed that this member needs to be changed in some way so that he or she will behave in a more acceptable manner. Often, an appointment will be requested for this individual in the hope that the problem can be worked out in therapy.

The first task of the clinician often becomes that of convincing clients (indeed, insisting to them) that all family members be present for the sessions. It is simply not possible to operate from a social situational perspective without having access to actual observation of the sequences of communication, hierarchical disputes, and general structure of the family system. The unit of analysis for interpretation of the problem and subsequent intervention is the group, not the individual.

An important element of the strategic communication approach is formulation of the client's problem in a clear way. The client will often seek therapy when he or she feels upset or troubled but will find it difficult to state unambiguously what the problem is. The clinician must formulate the present problem so that it is (1) clearly identified and (2) capable of being solved. For example, "depression" is a more amorphous and more difficult problem to approach than is "failure to hold down a steady job" (Madanes 1981:21). The latter is not only more amenable to solution, but the solution is subject to empirical verification.

Resolution of the presenting problem is the predominant concern of the therapist, who assumes responsibility for the achievement of this task and should not lose sight of it. The clinician working from a strategic communication approach views the presenting problem as a metaphor for a persistent pattern of interaction within a social unit. By working on the presenting problem, the clinician is working on the relationships.

In one case we encountered, Mrs. Wassons, a 26-year-old woman, married four years, complained of a "lack of communication" in her marriage and requested an appointment for herself. At the clinician's insistence she agreed to schedule the appointment for both herself and her husband. Lack of communication is an amorphous, multidimensional concern. During the first session, however, it became apparent that both spouses were unhappy with their sexual relationship. Mrs. Wasson was withdrawing from her husband's physical advances, to their mutual dissatisfaction. The clinician elected to focus on the couple's sexual relationship as the presenting problem. Sexual withdrawal was identified as a manageable concern that could be treated.

It became apparent that an asymmetrical distribution of power, favoring the husband, characterized the marital relationship. Digital bits of com-

munication indicated that the wife was responsible for most of the housework and childcare, despite her full-time job. She felt her husband unjustly withheld information from her concerning details of custody disputes he was having with his former wife. (By the previous marriage he had a six-year-old daughter who lived with his ex-wife.) Mrs. Wassons feared their relationship was being affected by these disputes, yet she was impotent to deal with the issue, given her husband's unwillingness to discuss it. Her complaint is a metaphorical one. Her dissatisfaction with the paucity of information represents a broader concern — her lack of informed participation in the marital relationship. Her withdrawal from sexual activity is a means of addressing this lack of control and, thus, becomes a metaphorical response to her lack of power in the relationship with her spouse. Withholding sex becomes one of the few mechanisms available to the wife for exercising power and influence in an otherwise asymmetrical relationship. By observing this hierarchical incongruity, the couple's marital problem can be understood as a consequence of an imbalance in the distribution of power. Indeed, this arrangement has created the presenting problem and even made the problem necessary.

A typical sequence of interaction occurs as follows: Mrs. Wassons seeks information from her husband to enable her to participate more fully in decision making. He brushes her off; she withdraws from him in response. He approaches her sexually; she rejects his advances, further withdrawing from him. Notice that both spouses are made unhappy by the lack of sexual activity. It is often the case that the method employed by a person to deal with an unsatisfactory social situation is unfortunate in itself: the solution becomes a further problem. Interventions at the level of the "solution" are likely to be more effective than attacking the problems directly and are referred to as the level of "second order change." That is, the presenting problem is reinterpreted as a solution to a system-level problem (first order). Intervention by the clinician that affects second order change will ultimately affect first order change as well. The systems perspective on family interaction is critical to this approach. Thus, by sexually withdrawing, Mrs. Wassons is actually exacerbating the lack of communication she finds so ungratifying in the first place.

In the case of the Sanders, it was also the wife who first called to arrange an appointment. She told the clinical sociologist that she was "overly shy" and this was creating difficulties in her marriage. Although Mrs. Sanders was encouraged to make an appointment for both her husband and herself, she stated that her husband insisted she take the first step on her own (presumably as a first step toward overcoming her shyness). Since there was no alternative, the therapist agreed to see her alone for the first visit but emphasized that it was likely that Mr. Sanders would be asked to attend the next session and that Mrs. Sanders should advise him of this.

At the first interview it was apparent that Mrs. Sanders's complaint of shyness provided her with the opportunity to express dissatisfaction with her marriage. In particular, she felt that Mr. Sanders spent far too much time away from home, and when they were together, they were usually with other couples. Thus, they seldom spent time alone. This pattern was confirmed at the second interview, which Mr. Sanders attended. The clinical sociologist decided on a therapeutic strategy which initially would redefine the complaint of shyness in a less ambiguous way. The couple were told that Mrs. Sanders's shyness was simply a failure to assert herself and make her needs known. She was too accommodating of others to act in her own self-interest.

The presenting problem of the wife as "too shy" was similarly viewed by the clinical sociologist as a metaphor for power imbalance within the relationship. While Mrs. Sanders readily accepted the label of shyness to describe herself, it was apparent in individual interviews with her that she felt a considerable degree of resentment against her husband for his overall neglect of her needs and feelings. Mr. Sanders was ignoring their need as a couple for intimacy and time away from others. The wife's shyness was interpreted as a metaphor for both the couple's need for exclusive time together and an attempt to create a reason for such exclusivity. Unfortunately, since this solution by the wife meant that even the husband's family was excluded from their social life, it was a solution that fostered his resentment toward his wife — which resulted in the husband spending even more time away from home at his club. The result was a vicious circle analogically expressed in the wife's shyness and, at the same time, largely sustained by her response.

After identifying the social context of a client's problem, the therapeutic task is to shift the organization of the system in such a way that the presenting problem is no longer necessary. This is achieved by the assignment of directives that clients are required to carry out between visits. The aim of the directive is to change the patterns of interaction among family members, usually by offering a substitute for the problematic sequence of interaction that makes the presenting problem functional. Thus, the social system, rather than the individual, is the unit for therapeutic intervention.

For example, the Wassons' interactional pattern can be altered if the clinical sociologist can substitute a different method — one less dysfunctional than the present one — for affecting the asymmetrical distribution of power in the relationship. It was decided to deprive Mrs. Wassons of her power to withhold sex and to deal with the hierarchical incongruity by prescribing activities that would be more functional for the relationship, by their own definition. The couple were told that every evening they were to set aside fifteen minutes during which the husband would rub his wife's back. During this time she was to request information of him on any issue important to her. They would then be obligated to discuss the issue. Sexual activity was permitted only

on two prescribed evenings, following the back rubs, and at no other time during the week. It was the husband's responsibility to see that they did not have sex on the other evenings.

The purpose of this directive is twofold. First, by restricting the sexual activity of the couple to two specific evenings, sex is no longer an arena available for the power struggle. By requiring the husband to enforced abstinence on other days, the previous pattern of interaction involving rejection is disrupted. Second, a more positive interactional sequence is substituted for the previous pattern. Symmetry is pursued through the soothing but nondemanding physical giving of the massage and discussion of matters important to Mrs. Wassons. At the same time, the directive addresses Mr. Wassons's frustration over his wife's refusal to engage in sexual relations with him by requiring her to participate twice a week. (Prior to this directive the couple rarely had sexual relations.) Reciprocity in the relationship is encouraged by a directive that replaces a mutually frustrating sequence with a more constructive one.

In the case of the Sanders, the couple were told that it was possible to cure Mrs. Sanders's lack of assertiveness, but that this could be achieved only with the husband's active participation. They were informed that Mrs. Sanders's wish that her husband spend more time with her would be the focus of treating her lack of assertiveness. Whenever Mr. Sanders was to be away from home for more than two hours (and especially on Saturday and Sunday while at his men's club), he was to inform his wife.

The clinician instructed the wife that in order to assert herself she was to go shopping instead of remaining home alone at these times. Furthermore, she was told to buy something for her own personal use. The value of this item was to be based on the number of hours Mr. Sanders was to be away. In addition, Mrs. Sanders was directed to select a day twice a month on which the couple would entertain Mr. Sanders's family. Mr. Sanders could not visit the men's club on those days since he would be required to assist in preparations for the visit in ways Mrs. Sanders considered appropriate.

This set of directives was based on redefining the presenting problem of shyness in a way that made it possible for the clinician to deal with the underlying problem of asymmetrical power. By redefining the wife's problem as one of a lack of assertiveness, the clinical sociologist was able to enlist the husband's aid in solving the problem. It also prevented the husband from ignoring his wife's need without incurring a cost — which is exactly what the wife's symptom of shyness was designed to achieve. To give Mrs. Sanders a sense of power over her husband's activities, especially the time he spent at the men's club, the shopping directive allowed her to influence the amount of time Mr. Sanders was away from home — something she had not been able to do in their two years of marriage. Finally, Mr. Sanders was given an incentive for complying with these directives by negotiating the couple's agreement to invite

his family to their home every other weekend. The aim of these tasks, as in the case of the Wassons, was to shift the pattern of interaction from one of mutual frustration to one of mutual satisfaction.

Conclusion

The strategic communication approach to family therapy represents a sociologically based model for the conceptualization of and intervention in everyday problems of social relationships. Sociological concepts such as power and control, function and dysfunction, system and interaction pattern, role and exchange, serve as a framework for relationship analysis. SCAFT is not the only sociologically oriented form of therapeutic intervention; it is, in our opinion, one that lends itself well to further explanation and development by clinical sociologists.

NOTES

1. We wish to thank the anonymous reviewers for the *Clinical Sociology Review* for their helpful comments on an earlier draft of this paper. For alternative approaches in clinical sociology to individual and family therapy — utilizing the social behavioristic perspective of G. H. Mead — see Hurvitz 1979 and Straus 1982.

2. For an interesting historical view of the child guidance clinic in relation to clinical sociology, see Wirth 1931.

3. For the sake of simplicity and because of space limitations, we have omitted reference to marital therapy and avoided entirely the question of its relationship to family therapy. It is our opinion that the distinction between the two is at present much less important than it was a decade ago. For a discussion from that time period, when the two could be seen independently, see Olson (1970).

4. Haley provides a connection not only between the two Palo Alto groups, but also between the Mental Research Institute and the Philadelphia Child Guidance Clinic where he consulted with Minuchin, Montalvo, and Erickson. In a sense this collaboration represents a fertile interchange between Bateson's communication ideas and Parsons's structural-functional perspective on the family.

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